PRINTED: 03/01/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND MAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/10/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445246	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON CITY HEALTH AND REHAB CENTER	283 W BROADWAY BLVD JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."*	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	K029 1. Headwall joints in the main mechanical room and biohazard room will be sealed with 3M Fire Sealant using the appropriate system for fire rating by the Maintenance Director. Appropriate system was requested by the Maintenance Director on 3/9/11. The louvered air return in the laundry hot water room has been removed and replaced by 5/8" drywall on both sides of the wall with joints taped and sealed. The Maintenance Director accomplished this on 2/24/11. 2. Other mechanical rooms were checked by the Maintenance Director on 2/28/11 for headwall fire sealant and penetrations and necessary repairs will be made when appropriate system has been approved. 3. Monthly audits will be placed on the monthly PM checklist for maintenance. Maintenance personnel were educated by the Administrator on 3/11/11 to accomplish these audits and to make the necessary repairs as needed. 4. Audit results will be reported by the Maintenance Director to the Quality Assurance Committee for review.	3/21/11

42 CFR 483.70(a)
K3 BUILDING: 1-story Type II(222), unprotected, non-combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1976
K7 SURVEY UNDER: 2000 EXISTING
K8 170-bed SNF/NF

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to assure hazardous area ' s fire rated construction is maintained.
The findings include:
Observation and interview with the Maintenance Director, on February 23, 2011 at 1:00 p.m. confirmed unsealed headwall joint in the 2-hour rated wall of the main mechanical room and biohazard storage room.(NFPA 101, 19.3.2.1)
Observation and interview with the Maintenance Director, on February 23, 2011 at 1:30 p.m. confirmed the laundry hot water heater room had a louvered air return opening in a fire rated wall..

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Waldrop
TITLE: Administrator
(X6) DATE: 3/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	Continued From page 1 (NFPA 101, 19.3.2.1)	K 029	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."*	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure exits discharge paths were lighted. The findings include: Observation and interview with the Maintenance Director, on February 23, 2011 at 2:20 p.m. confirmed the outside lights at the exits from the hall by the employee break room and the exit by room 214 were provided with a single light. The exit discharge was not illuminated so the failure of any single lighting fixture (bulb) would not leave the area in darkness (NFPA 101, 7.8.1.4).	K 045	K045 1. Two bulb fixtures were purchased on 3/8/11 and will be installed on 3/14/11 at the noted exits by Maintenance personnel. 2. Other exits were checked for two bulb fixtures by the Maintenance Director on 3/4/11 One other exit was found needing a two bulb fixture and will be replaced on 3/14/11. 3. Monthly checks of exit lights was placed on the Monthly PM checklist. Maintenance personnel were educated on 3/11/11 by the Administrator to accomplish these checks and to make the necessary replacement of lights. 4. The maintenance director will report results of the Monthly PM checklist to the Quality Assurance Committee for review.	3/21/11
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	K050 1. The missing drill was noted in the log. 2. Logs for emergency drills were reviewed for completeness by the Maintenance Director on 2/28/11.	3/21/11

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K 050	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure fire drills were conducted quarterly on each shift . The findings include: Record review on February 23, 2011 at 9:00 a.m. confirmed a fire drill had not been held for the 2nd shift of the 2nd quarter of 2010 .	K 050	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."*	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure fire extinguishers complied with the hydrostatic test requirements of NFPA 10-5.2). The findings include: Observation and interview with the Maintenance Director, on February 23, 2011 at 2:50 pm confirmed there was no 5-year hydrostatic test performed on the stainless steel K-class portable fire extinguisher located in the kitchen.	K 064	3. Check of emergency drill logs has been placed on the Monthly PM Checklist. Maintenance personnel were educated on 3/11/11 by the Administrator to accomplish these checks. 4. The maintenance director will report results of the Monthly PM checklist to the Quality Assurance Committee for review. K064 1. K-class fire extinguisher in the kitchen was removed for hydrostatic test and replaced with one with a current hydrostatic test by Sevier Fire and Safety on 2/25/11. 2. All fire extinguishers were checked for proper hydrostatic and 6-yerar maintenance by the Maintenance Director on 3/9/11	3/21/11
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 066	3. Log sheets have been developed and will be kept with fire extinguisher certification. Maintenance personnel were educated on 3/11/11 by the Administrator to utilize the log sheets and the checklist. 4. The maintenance director will report the status of fire extinguisher checks to the Quality Assurance Committee for review.	

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K 066	Continued From page 3 area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure smoking areas were provided with metal containers with self-closing cover devices (NFPA 101, 19.7.4 (4)). The findings include: Observation and interview with the Maintenance Director, on February 23, 2011 at 3:00 p.m. confirmed two (2) of two (2) smoking areas had were not provided with metal containers with self-closing cover devices.	K 066	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."* K066 1. New metal ash disposal cans were ordered on 3/8/11 and were placed in each smoking area by the Maintenance Director. 2. Smoking areas were checked for required equipment by the Maintenance Director on 2/28/11. 3. Monthly checks of smoking areas will be added to the PM Checklist and to the Mock Survey Checklist. Maintenance personnel were educated on 3/11/11 by the Administrator to accomplish these checks and to correct any issues. 4. The maintenance director will report the results of PM checks to the Quality Assurance Committee for review.	3/21/11